Choosing a career path in GI : Private practice

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My background

Private practice vs employed GI

- Private practice physicians:
  - Have an ownership mentality in their practice
  - Not just a salaried employee….
    - Opportunity for ownership and growth in their practice
    - Opportunity for ownership in ASC's
    - Ancillary revenue streams: Pathology, Anesthesia, Infusion, Pharmacy, Research ,etc

Private practice vs employed GI

- Can react quickly to GI specific challenges

- Provide **high quality and affordable care**
  - Rise in patient consumerism
  - An important differentiator between hospital employed docs
  - ASC vs HOPD rates
  - Subtantial facility fees are attached to professional fees when seeing an employed physician

Clinical practice: private practice

- Customization: One size does not fit all…
  - Full time partnership track
  - Part-time productivity partners
- General GI vs specialized focus
  - IBD
  - Interventional GI
  - Hepatology
  - Pancreaticobiliary
  - Hemorrhoidal therapies
  - GI motility

Learning and Leadership in private practice

- Myths:
  - Private practice (PP) physicians do not see complex patients
  - PP are just in it for the money and are "scope jockeys"
  - PP are not up to date on current clinical practice guidelines

- Reality:
  - We see and treat many complex patients
    - Transition of pediatric IBD patients from Cincinnati Children's
    - Hepatology/ Cirrhosis pre transplant workup.
    - Complex cancer care- multidisciplinary team approach
  - Ample educational opportunities
    - Monthly IBD/Liver meetings offered at Gastro Health
    - Best clinical practices are accessible in EHR
    - CME stipends to encourage meetings, etc
    - Gastro Health Summit at yearly ACG meeting
  - Leadership opportunities (local, regional, national)
  - Participation in state and national societies
    - ACG, ASGE, DHPA, OGS, CCFA

Short term vs long term view

- Shorter term view:
  - Many fellows have substantial debt coming out of training
  - Hospitals can typically offer large up front salaries to entice fellows to join
- Longer term view:
  - Good initial contracts with some “delayed gratification”
  - Very compelling financial upside from many of the practice’s revenue streams
  - Maturing of equity in the practice

Questions to consider when joining a practice

- Who are the physician and business leaders in the practice?
  - What is the culture of a practice?
  - What is physician involvement in the leadership structure?
- Number and demographics of partners in the practice?
  - Growing or shrinking numbers?
  - Diversity of providers…
  - How successful has the group been in recruiting new partners?
- How long have partners stayed on with the practice?
  - How many docs have left the practice?
  - What were the reasons for leaving?

Questions when joining ??

- What are clinical expectations of new docs ?
  - Inpatient vs outpatient ratios
  - Endoscopy vs office splits
  - Block time allotment
- What is the call structure /frequency of call?
  - Equal or disproportionate for new docs
  - Work/Life balance
- What is a typical pathway to partnership?
  - How long is the average to obtain this?
  - Timed (1-2 years) vs hitting a specific productivity threshold (relative to other partners)
  - Is there a financial buy in or is it a buy in with “sweat equity”?
    - How is this buy in financed?
  - What ancillary revenues will a full partner participate in?
    - How are ancillary revenues divided?
      - Equally vs based on productivity of individual
      - How are these revenues “turned on”?

Decision time: Considerations for fellows

- Make a rank list of the criteria most important to you!
  - Stability of the practice/Fit of the practice
  - Practice's preparedness for future changes in payment reform
  - Track record of recruitment
  - Financial: ability to provide for family and pay down debts (with a long term view)
  - Work:life balance
  - Ability to customize your clinical practice

Private Equity(PE): myths

- Myths/Concerns of fellows:
  - PE is there to change the way docs practice medicine
  - PE will interfere and meddle in the day to day operations of a clinical practice
  - PE is merely a cash out option for senior docs and young docs get left “holding the bill”
  - PE is a failed model in medicine

Private equity: reality

- PE is a way for independent practices to gain meaningful scale while maintaining their independence from hospitals
- An equity partner enters into a time-limited partnership between a physician practice(s)- (typically several years long)
  - Physicians will sell of a small percentage of their companies future earnings to the equity partner
  - Physicians will maintain the majority percentage of financial ownership in the company with PE having minority ownership
  - This is a symbiotic relationship- all partners are "rowing in the same direction"
- Equity partner will support local leadership in operations and growth initiatives for the practice.
- Equity partner will infuse capital into the company to help accelerate the growth strategies of the local practices
  - Adding new ancillary lines or enriching existing ancillaries
  - Expanding regional footprint via recruitment and adding new physician practices
  - Growth of the practice enhances the value of the practice

Private equity: Myth vs reality

- Reality:
  - Increased regional density of physicians in a market has advantages:
    - Contracting: Leverage with insurers and large employers
    - Economies of scale: Dividing costs over more providers.
      - Better purchasing negotiations
  - New docs joining Gastro Health will be offered equity at the time of joining the company without a financial buy-in
    - Shares of stock in the company that can appreciate over time
    - This will vest at the time of a future PE recapitalization if the doc fulfills the vesting criteria.
  - Private equity can invest in critical infrastructure buildout
    - IT, cybersecurity, legal, HR, EHR, Endo writers, RCM and scheduling improvements, etc

Questions???